Leicestershire Partnership
NHS Trust

Organisational Risk Register
July 2023

Based on the risk appetite matrix produced by the Good Governance Institute

Risk No: 59	Date included	29 November 2021	Date revised	10/07/2023
Objective: S	High Standards			
Risk Title:	Lack of staff capacity is causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.			
Risk owner:	Exec: Operational Directors and Director of Nursing, AHPs and Quality		Local: Head of Patient Safety	
Governance:	Quality Forum / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:	• Incident reporting policy, centralised SI reporting and oversight process, and approved exec sign off process • Incident investigation training monthly rolling programme • DMH pilot programme – new cyclical process for managing and learning from SI's • Initial meeting held with the ICB for PSIRF to determine LLR ICB approach – ongoing engagement within ICB / System • Recruitment of additional SI investigators and clinical governance officers • Learning lessons community of practice • Approved SI sign off process
Gaps:	• Delay due to capacity focussing on clearing the backlog

Assurances

	Source	Evidence	
Internal:	• Reports/ minutes from Incident Oversight Group, Incident Review Meeting and Quality Forum and Executive Team. • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report • Increased frequency of sign off meetings • Collaboration with the Group learning lesson exchange group • Clinical governance structure • Directorate improvement plans in place monitored via Incident Oversight Group	• Patient Safety Trust Board reporting includes patent stories to support learning • Directorate improvement plans - monitored via EMB, IOG and through to Quality Forum • Early learning from Incident Review Meeting • Reduced rate of complaints from families relating to SIs due to enhanced engagement. • Trajectories for delivery of the over 15-day incident closure backlog complete and monitored through EMB.	Assurance Rating Amber
External:	Source: • CQC Inspection 2021 • ICB sign off and feedback for SI reporting • Accreditation feedback from SIRAN – positive on quality • Patients and family feedback – improving	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • ICB – number of reports signed off / number returned for additional work	Assurance Rating Green
Gaps:			

Action

Date:	Actions:	Owner:	Progress:	Status
Ongoing	Directorate and patient safety services working together to clear the backlog of SIs	TH/SL/HT/TW	Ongoing –touchpoint scheduled for August 2023	Amber
Ongoing	Closure of action plans within timeframes across the directorates.	TH/SL/HT/TW	Ongoing – touchpoint scheduled for August 2023	Amber
		TH/SL/HT/TW	Ongoing – touchpoint scheduled for October 2023	Amber
Ongoing	Moving towards PSIRF			Amber

Risk No: 61	Date included	29 November 2021	Date revised	10/07/2023
Objective: S	High Standards and Equality, Leadership, Culture			
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Education, Training and Development	
Governance:	SWG / PCC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- Mandatory and Role Essential Training Policy, Study Leave Policy, Safer staffing policies and guidance
- National and local People Plan
- Mandated clinical supervision
- Role applicable competency framework / Annual training needs analysis
- Process for amending compliance requirements to position numbers / Manager compliance and DNA reports live on ulearn
- Deteriorating Patient and Resus Group in place to progress and reviews clinical incidents and staff skills, resus drills, Level 3 ILS and Level 2 BLS
- Reporting and monitoring of monthly course unutilised spaces and cancelled courses/places / New report of Mandatory Training SME and course update logs to TED
- Reporting on DPA training compliance for pre-learning/new starter goes to DMT monthly
- Level 3 ILS training plan agreed for 113 HRCG agency RNs who regularly work in in-patients, training to be completed by August 2023
- HRCG agency staff compliant with the national skills framework requirements, external audited and compliance reported through the Contract Review meeting
- Bank staff provided with clinical supervision through 0.4wte clinical education leads for bank
- EQIAs for a Trust wide 'hard stop' deployment of Thornbury HCA July 2023.
- Additional training provided by HRCG to regular agency nurses to complete ILS (L3)

Gaps:

- Elements of mandatory and role essential training compliance for our non-substantive/bank workforce

Assurances

	Source	Evidence	Assurance Rating
Internal:	• SWC , Directorate Workforce groups , retention working group • Training Education and Development Group (TED) • Quarterly workforce triangulation to ops exec - hotspots and action • LLR People Programme Delivery Group • Workforce planning supply Trust Approach • Workforce and safe staffing, tipping points and actions aligned to OPEL levels and governed through SWC • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting • Learning from SI's and quality improvements • Monthly clinical education forum • Winter BAF actions reviewed at Winter Committee	• Increased compliance for ILS, NEWS 2 and sepsis for substantive staff • Supervision compliance report- monthly • Noc trust board and SEB deep dive • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan. • Training capacity DNA spaces monitored at Training Education Development Group Monthly • Monthly pre-learning report on DPA training • SME report to TED/SWC • New PCC discussion on agency compliance • Managers live view of staff compliance on ulearn • EMB paper from Directorate execs on trajectory to compliance	Assurance Rating Green
External			
Gaps:			

Actions

Date:	Actions:	Owner:	Progress	Status
Sept 23	• To increase capacity for face-to-face Pressure Ulcer Prevention training	Laura Brown	SBAR presented to DMT – awaiting decision on funding.	Green
Aug 23	• Review requirement for the reinstatement for bank staff to be compliant before booking shifts	Jane Martin	Review at Bank Learning Group / EMB	Amber
Sept 23	• Review benchmarking for compliance reporting across the Group and the system	Nicola W/Alison O'D	Reviewed at EMB June 23. Further benchmarking to be undertaken	Amber

Risk No: 64	Date included	29 November 2021	Date revised	17/07/2023
Objective: T	Transformation			
Risk Title:	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.			
Risk owner:	Exec: Director of Strategy and Partnerships		Local: Head of Strategy	
Governance:	Transformation Committee / FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	2	3	6
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

Controls

Description:

- Engagement and support to LLR wide system strategy meetings, including ICB/ICP meetings, system executive meetings, local authority scrutiny and health and well-being board meetings.
- A clear Step Up to Great Strategy (SUTG) developed and shared with stakeholders. The SUTG strategy sets out a 3 year vision and is supported by an annual operational delivery plan. This annual delivery plan enables a regular conversation with our stakeholders to understand our changing environments.
- Engagement and support by LPT to the development of models of Integrated Care within LLR
- Project development risk registers
- SUTG delivery plans

Gaps:

- Sufficient oversight of individual service sustainability

Assurances

	Source:	Evidence:	
Internal:	Commissioning & Collaborative Committee and first meeting Transformation and QI Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes Business pipeline report	Assurance Rating Green
External:	Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating Green
Gaps:	Further building of our work with voluntary and community organisations		

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept 23	Delivery of the national innovator supports new ways of working and LPT's role in the system as a convener and coordinator of services.	Group Director of Strategy & Partnerships	ongoing	Green

Risk No: 66	Date included	29 November 2021	Date revised	12/07/2023
Objective: E	Environments			
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.			
Risk owner:	Exec: Chief Finance Officer	Local: Associate Director Estates & Facilities		
Governance:	Estates Committee, FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls

Description:

- Approved Strategic plan for the elimination of dormitory accommodation
- New Hospitals Programme (NHP) Expression of Interest submitted
- Refresh of Mental Health inpatient Strategic Outline Case and bed modelling
- Triple R outputs
- Estates Strategy refresh in progress
- Capital resource prioritisation framework
- Refreshed SUTG strategy 2021

Gaps:

- Finalise ward moves to confirm phasing order for dormitories. Works continue on programme.
- Directorate and enabling business plans to support wider Estates plan development
- Lack of outcome of New Hospital Programme bid

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: • Strategic Property Group • Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee. Directorate Health and Safety Action Groups	Evidence: • Reports to EMEC • Consideration of estates strategy with directorates • Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance	Assurance Rating Amber
External:	Source: • CQC Inspection 2021, 2022 • Consideration of NHP expression of interest submitted 2022. • Estates 5 Year Plan (Archus)	Evidence: • CQC report • NHSEI updated monthly on track.	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Ongoing	• Implementation of Dormitory Eradication programme.	Assoc Director Estates & Facilities	• Dorm scheme - remains on plan. Additional work identified as part of the scheme (Welford, Langley and Kirby)	Amber
July 23	• Production of the Trust's estates 5-year plan	Assoc Director Estates & Facilities	• Consultation complete	

Risk No: 67	Date included	29 November 2021	Date revised	12/07/2023
Objective: E	Environments			
Risk Title:	The Trust does not have identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.			
Risk owner:	Exec: Chief Finance Officer		Local: Chief Finance Officer	
Governance:	Estates Committee, FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	4	12
Tolerance Level Moderate 9-11 (Appetite Regulation-Cautious)			

Controls

Description:	• Chief Finance Officer is Executive lead • Self-assessment undertaken on the Green Plan requirements, taken through Board Development and Strategic Executive Board • LLR Greener NHS Board authentic representation of the position and request for support made • Job Description drafted for Head of Sustainability, and Sustainability Manager. • 100% renewable energy to be purchased. • New Group Sustainability Committee with NHFT	
Gaps:	• Lack of data on carbon footprint. • Lack of historic Sustainable Development Management Plan. • Chapter leads to be confirmed • Job Descriptions awaiting banding and funding approval • New Joint Sustainability post not approved by Vacancy Control Panel	

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: • Green plan approved	Evidence: Board and committee meetings	Assurance Rating Amber
External:	Source: • LLR Green Board • Work to share across the Group with NHFT knowledge and experience on sustainability	Evidence: • Green Board • Committees in Common	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept 23	• Set out action plan based on existing resource and without recruiting to Sustainability post		Post not approved by LPT Vacancy Control Panel	Amber

Risk No: 68	Date included	29 November 2021	Date revised	17/07/23
Objective: G	Well Governed			
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.			
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information	
Governance:	Data Privacy Committee / FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)

Controls

Description:

- Executive senior information risk officer (SIRO) sponsorship
- Information asset owners in place
- Clinical system training in place
- Performance management framework (which includes the 6 dimensions of data quality)
- Data quality policy and procedure
- Data Quality Kitemark & Framework approved by DQC, will be implemented for 22/23 reporting.

Gaps:

- Incomplete data quality reports for local and national data sets
- Insufficient monitoring of data quality incidents does not allow for learning opportunities
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data
- Ownership of data quality across the Trust – being picked up with support of Change Champion attendance at Data Quality Committee
- Accessible data for front line clinical teams
- Recorded demographic data does not support the health inequalities agenda, and could delay Trust understanding & action in this area
- Incomplete demographic data could impact on LLR system's ability to understand & manage Population Health Management for LPT patients
- SNOMED recording at point of care - non compliance from 01/04/23; action plan & oversight group in place, team in dialogue with NHSE.

Assurances

Internal:

- Performance review meetings include Directorate level metrics
- FPC / Trust Board
- Clinical audit / Annual record keeping audit
- Data security and protection toolkit self assessment
- Regular oversight reports from the IM&T Committee
- Data quality committee
- Local Risk register

Evidence:

- DSPT 'standards met' annual submission made in June 2023
- Data quality actions reported to FPC via Data Privacy Committee
- Local risks reviewed in Data Privacy Committee
- Delivery of phase 1 21/22 data quality work plan
- SEB approved Data Quality Plan Implementation and Campaign on 02/12/22

Assurance Rating Green

External:

Source:

- Annual benchmark reporting against peers
- Internal audit programme for data quality and reporting
- Internal audit review of our data security and protection toolkit (DSPT)
- Commissioner scrutiny

Evidence:

- Data quality framework 21/22 audit – significant assurance
- DSPT 23/24 360 assurance audit – Significant assurance

Assurance Rating Green

Gaps:

- Data quality group revised approach started in February 2021, phase 1 has defined the frameworks for quality data, phase 2 of action plan needs to fully embed the approach

Actions

Date:	Actions:	Owner:	Progress:	Status
Dec 23	Phase 1 delivery of health inequalities data recording	SM	Implementation plan in place	Green
Dec 23	Continue to implement SNOMED	SM	Clarity for 23/24 resources agreed with all parties and updated at SEB	Amber
Dec 23	Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM	Data quality plan approved by DQC in December 2022 & approved by SEB	Green

Risk No: 72	Date included	29 November 2021	Date revised	17/07/2023
Objective: R	Reaching Out			
Risk Title:	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.			
Risk owner:	Exec: Director of Strategy and Partnerships		Local: Head of Strategy	
Governance:	Transformation Committee / FPC / Board – Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance Level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- We are supporting our most vulnerable in society; raising health equity across LLR, through attendance at LLR Health inequalities meetings.
- Our people plan and our system people plan supports a sustainable local community in LLR, through the development of our workforce and the support to staff and the development of new roles.
- We are seeking to positively support environmental, economic & regeneration improvements, policies and practices in LLR
- Board development programme

Gaps:

- Publication of the LPT response to the NHS Green plan
- The development of our own information and data to address inequalities
- Internal capacity to deliver and transform our planned change
- Social Value Charter

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Regular attendance at system meetings Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes	Assurance Rating: Green
External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating: Green
Gaps:	Calculating the impact/value of the reaching out programme to LPT and to our communities.		

Actions

Date:	Actions:	Owner:	Progress:	Status
July 23	Social value framework co-produced, meetings held with boards, Senior leaders and discussions with teams	David Williams	Ongoing	Green
July 23	Development of inequalities data in an accessible format	David Williams/ Information Team	Some data complete, exploring with performance how this can be available to all. Local Public health team will provide the analysis.	Green
July-Sept	Presentation to Directorate Meetings, Strategic Exec Board and Senior Leadership Forum of the Inequality data	David Williams	Presented to MH senior leadership team, date requested for SLF. Expected presentation to SEB in September due to annual leave.	Amber

Risk No: 73	Date included	29 November 2021	Date revised	10/07/2023
Objective: E	Equality, Leadership, Culture			
Risk Title:	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion	
Governance:	SWC / PCC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Tolerance Level Significant 16-20 (Appetite People - Seek)			

Controls

Description:

- Our Future Our Way / Leadership behaviours (which includes an EDI specific behaviour)
- 6 high impact action submission has been signed off by EDI Workforce Group
- Anti – Racism strategy co production with NHFT part of group model
- EDI Taskforce - 10 action areas agreed.
- 8th We Nurture OD targeted sessions for BAME staff delivered
- Reverse mentoring. Second cohort completed and third cohort launched.
- National and LPT People Plan priorities being addressed.
- WRES and WDES action plans revised annually and being implemented.
- Zero tolerance campaign launched
- Equality Objectives within staff appraisals
- Cultural Competency Programme
- Group TAR programme of work

Gaps:

- Improved delivery against outcome measures / WRES and diversity metrics
- Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions (Inclusive talent management implementation)

Assurances

Internal:

- Diversity workforce dashboard reported to SWC
- Regular reporting of equalities progress against measures to level 2 and 1 committees
- Annual Equalities Action Plans revised and produced for WRES, WDES and GPG
- Staff survey results inform action planning

- EDI annual report to EDI committee / EDI group
- WRES/WDES DATA published action plan to QAC/SWC – highlight report that include assurance ratings.
- Staff survey report Trust Board – results
- WRES and WDES data reports to QAC (August 22)
- WRES / WDES staff survey results reviewed at EDI groups
- WRES EDI reviewed at SEB June 23

Assurance Rating Green

External:

Source:

- System wide EDI Taskforce established and identified seven priority areas for implementation
- National scoring 0.7 out of 4

Evidence:

- EDI Taskforce – highlight report assurance rating
- CQC feedback
- WRES and WDES metrics have improved in most areas.

Assurance Rating Amber

Gaps:

Actions

Date:	Actions:	Owner:	Progress:	Status
Sep 23	Self-assessment against the National EDI delivery framework and refresh WRES WDES action Plans	Haseeb A	Ongoing – aligning to National EDI plan	Amber
March 24	Delivery of Group (LPT/NHFT) EDI programme – action plan in place	Chris Oakes	Ongoing	Amber
Oct 23	NHSE ET Ruling and Lessons Learned / action plan is in place	Haseeb A	Ongoing – EDI workforce group oversight	Amber

Risk No: 74	Date included	29 November 2021	Date revised	10/07/2023
Objective: E	Equality, Leadership, Culture			
Risk Title:	The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, leading to increased sickness levels.			
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD	
Governance:	SWC / PCC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Tolerance Level Significant 16-20 (Appetite People - Seek)			

Controls

Description:

- Wellbeing, sickness management policy
- Counselling service
- Anti bullying harassment and advice service
- Staff Physiotherapy scheme
- Health and wellbeing champions
- Leadership Behaviours Framework
- NHS People Plan national support
- Staff risk assessments / stress indicator
- System mental health HWB hub
- Mental health and Wellbeing Hub
- Occupational health service wellbeing strategy and implementation plan
- Occupational health department / Staff reps / Amica
- Health and Wellbeing Lead / People Promise Manager
- Rolling programme of health and wellbeing roadshows
- Ongoing deep dives on absence across the Directorate

Gaps:

- The ongoing NHS challenging environment and economic situation may impact on staff wellbeing

Assurances

	Source	Evidence	Assurance Rating
Internal	• Financial HWB support task and finish group • Daily Sickness absence monitoring • Sickness and workforce reports to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to OH and Amica	Evidence: • Sickness absence rate LPT • Staff side – feedback • Action plan reporting through SG AND ICC • People plan • HWB Guardian update to Board Sickness deep dive received at SWG	Assurance Rating Green
External	Source: • Be well midlands staff engagement process by NHSEI • NHSI reporting • LLR workforce group • Health and wellbeing taskforce group	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Ongoing	Deep dive reviews of sickness management	Claire Taylor	Ongoing	Green
Sep 23	Create an action plan with KPIs to be monitored through workforce groups and SWG	CT	Ongoing	
Aug 23	Mental Health First Aid Training – internal offer to support health and	AoD	Paper to TED August 2023	

Risk No: 75	Date included	29 November 2021	Date revised	12/07/23
Objective: A	Access to Services			
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.			
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors	
Governance:	EMB / FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls

Description:

- Access Policy
- Access Group
- Waiting list management approaches and Standardised Operational Processes applied to waiting lists in all services including waiting list validation, patient tracking lists, demand capacity modelling .
- Trajectories in place to plot performance of waiting times improvement in prioritised services.
- Service pathway re-design including measures as part of the Step up to Great MH transformation programme
- System planning (design groups) established to manage patient flow and investment
- Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information
- Agency locum sessions
- Waiting list initiatives and extra sessions

Gaps:

- Capacity and resources
- Recurrent funding for non-recurrent solutions
- 23/24 access priorities to be agreed
- Impact of industrial action by medical staff

Assurances

	Source:	Evidence:	
Internal:	• Executive Management Board – Performance reviews • Directorate level deep dives. • Waiting time performance reported to Finance and Performance Committee • Checks of safety of patients waiting • Directorate risks including access where appropriate	• Performance dashboards and reporting to DMTs, EMB and Trust Board • Trajectory for improvement and measurement against trajectory • Transformation plans	Assurance Rating Amber
External:	• Internal Audit – Remote Consultations 2022/23 • Internal Audit – Patient Experience 2022/23 significant assurance • System performance monitoring • National benchmarking data • Quality / Contract Monitoring with ICB • LDA Collaborative	NHSE QRSM LDA regional oversight board delivery plan / metrics	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Ongoing Ongoing	Delivery of Medical workforce plan Delivery of priority service plans and associated trajectories; FYPCLD – Comm Paeds / Audiology/ CAMHS Eating Disorders/CAMHS Access/SALT/CYP Physio/Adult Autism Diagnostic Service. (ND separate risk 91) DMH – CMHT/ ADHD/memory assessment / TSPPD / CBT/DPS. CHS – CINNS/ Continence/SALT.	Operational Directors	In progress – ongoing. Plans being delivered – next touchpoint August 2023 Overseen by Access Delivery Group and oversight at EMB Agreement by ICS to change waiting time targets in line with clinically agreed timelines.	Amber

Risk No: 79	Date included	29.03.22	Date revised	17/07/23
Objective: G	Well Governed			
Risk Title:	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches			
Risk owner:	Exec: Director of Finance & Performance/SIRO	Local: Head of Data Privacy		
Governance:	Data Privacy Committee / FPC/ Board Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Tolerance Level Significant 16-20 (Appetite Quality - Seek)			

Controls

Description:

- Multiple tiers of controls including ongoing assessment and scanning of boundaries, geo-blocking and supporting information security policies
- Governance controls – reporting to Data Privacy and IM&T Committee on Cyber and Information Security / SIRO Structure / mandatory training / bespoke training
- Audits on Information Security Management System (ISMS), ISO, DSPT – with significant assurance
- Continuity Planning and Disaster Recovery exercises and reviews. Business Continuity Plans / Incident Response capabilities – active real world testing e.g. Russian Attack
- Risk averse position taken in relation to mobile and remote working such as requests for working abroad with a default 'no' position
- Regular One Minute Brief messages and communications reminding staff how to recognise a potential Phishing email or request for credentials
- Increased collaborative working with other NHS organisations to share intelligence and learning
- Membership of Cyber Associated Network for early notification of national and local issues
- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Where weaknesses/vulnerabilities are identified there is constant learning and immediate remediation plans in place
- Home working risk assessment includes confidentiality clauses and accessing clinical systems, which requires signature of staff member
- Phishing simulation exercise August 2022 enabled assessment of Trust's vulnerability – further planned

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Increase in NHS cyber threats seen affecting suppliers that the NHS uses
- Some staff clicked through links from August phishing exercise
- Staff continue to click through, as demonstrated in recent attack - c10% of staff who received the e-mail (similar % to August)
- Audit and assurance regarding the testing of Business Continuity Plans fed into the 2023/24 planning process for internal audit plan
- Use of AI/Chat GPT is an emerging issue in the Trust

Assurances

	Source:	Evidence:	
Internal:	Cyber security working group Bi-Monthly report to Data Privacy Committee LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy Review & testing of disaster recovery and business continuity processes in response to real world testing Cyber metrics reported through DPC Dashboard Reporting of incidents	Accreditation reports Output reports and remediation plans Dashboard for Committee meeting Data breach reports to Data Privacy Committee Business Continuity plans Mandatory training compliance reports	Assurance Rating Green
External:	LHIS ISO Audit KPMG Understanding IT 21/22 Audit / 360 Assurance DSPT Audit 21/22 DSPT submission – standards met 21/22 External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting 360 Assurance Cyber security governance Audit 22/23	Accreditation report Audit reports / 360 substantial assurance NHS Digital submission Significant assurance	Assurance Rating Green
Gaps:	The Trust is reliant on Business Continuity plans of suppliers being adequately able to respond to cyber attacks in a timely manner		

Actions

Date:	Actions:	Owner:	Progress:	Status:
Aug 23	Data Privacy Committee consider trust wide comms around use of AI/Chat GPT	SM		Green
Mar 24	Multi Factor authentication will be mandated by NHS Digital for NHS mail accounts	HIS	DPC discussion planned. Working group set up; priority areas will be set up first e.g. finance/procurement	Green
Mar 24	IT Business continuity plan for prolonged downtime part of 23/24 internal audit plan	SM		Green

Risk No: 83	Date included	August 2022	Date revised	17/07/2023
Objective:	High Standards			
Risk Title:	Inadequate access to and adoption of new technology hinders staff ability to maximise the advantages of the technology which impacts on the delivery of patient care.			
Risk owner:	Exec Lead: Group Director of Strategy and Business Development | Local Lead: Group CDIO / Director of LHIS			
Governance:	IMTC, EMB & FPC			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	3	3	9
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- 24 hour on-call availability of HIS
- Online training on SystmOne available to all SystmOne users
- Business Continuity Plans in every service to ensure continuity
- Constant Cyber protection from HIS, with reinforcement of local awareness for all staff
- Operating policies for virtual appointments
- LPT digital plan
- LLR Care Record

Gaps:

- Identification of areas of Wifi coverage issues
- Usability of the system
- Access to the system
- Staff knowledge, training and culture.
- No clear route for the escalation of staff concern re systems

Assurances

	Source:	Evidence:	
Internal:	• Incident reporting • Monthly Directorate meetings with HIS contacts • IMT Delivery Group • IMT Committee	Report summaries and regular meetings DMT meetings Minutes and actions from the meetings Minutes and actions form the meetings	Assurance Rating Amber
External:	• CQC inspections/MHA visits • LLR Digital Strategy and Delivery meetings	CQC inspection report 2022 Notes from the meetings	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress	Status
Sept 23	• Audit for consistency of IT connectivity	LHIS	Scheduled update for TB – Sept 23	Amber
August 23	• Staff training for SystmOne	Julia Bolton	Ongoing – next touchpoint review Aug 23	
August 23	• SOP for remote technologies – draft to IM&T, out for consultation ahead of being finalised	Julia Bolton	Ongoing	
Sept 23	• Digital Maturity Assessment – creation and implementation of action plan for 23/24	Gareth Jones Gareth Jones	Align with ICS priorities and support action planning – co production planned July / August – touchpoint in Sept 23	
Sept 23	• LPT digital plan		Drafted – presented TB development in June 23. Further co production planned July / Aug – touchpoint Sept 23	
Aug 23	• Clarity over escalation route for concerns raised by staff.	AS/DW		

Risk No: 84	Date included	August 2022	Date revised	10/07/2023
Objective: S	High Standards			
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high temporary staff usage, which may impact on the quality of patient outcomes, safety, quality and experience.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Assistant Director of Nursing & Quality	
Governance:	Quality Forum and SWC / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8
Tolerance Level Significant 16-20 (Appetite People-Seek)			

Controls

Description:

- Safe staffing policy / induction policy for substantive and temporary staffing including agency staff
- Revised dynamic risk assessment process for additional staffing requests
- Weekly safer staffing and safety huddle
- Staff forecasting and quality impact assessments
- Decision tool and escalation framework for resolution of staff shortages
- Staffing escalation plans for business continuity and surge plans
- Direct support programme with NHSE for reducing HCA vacancies
- Nursing and midwifery self-assessment tool – NHSE / workforce leads
- International nursing and AHP recruitment programme and comprehensive induction in place
- LLR AHP faculty – short term funding to support recruitment and retention – recruitment video for AHPS and support worker career and appraisal tool
- Transition preceptorship programme and two WTE education and pastoral support nurses – accredited with the pastoral quality award
- Weekly vacancy control panel (includes nurse representation).
- Daisy Award
- Preceptorship quality mark application
- Flexible working as part of the People Promise Exemplar Programme

Gaps:

- National and local workforce shortages – particularly in LD, mental health, medical mental health workforce, AHPs (OT and Physiotherapy) and community nursing
- Increased demand

Assurances

Internal:

Bank clinical supervision report to the professional standards group with themes and trends for monitoring bank staff induction, support and skills
Daily safe staffing huddle, Winter Preparedness 2021 Nursing Safer Staffing BAF
National safe staffing return
Monthly Safe staffing report including monitoring harm / nurse sensitive indicators
Reporting to Trust Board and level 1 assurance committee

- Self-assessment complete 4 key themes to enhance assurance, action plan developed
- Weekly situational and forecast staffing meeting
- Workforce and Agency Reduction Plan to New PCC

Assurance Rating Green

External:

- Internal Audit – Agency Staffing – advisory incl recommendations for improvement
- National reporting – fill rates and care hours per patient day - NHSE – improving reporting accuracy to reflect all additional skill mix roles. Need evidence in the national submission to flow through.

Assurance Amber

Gaps:

Actions

Date:	Actions:	Owner:	Progress:	Status
August 23	Embedding of Schwartz Rounds	D Rennie	On track with launch for August 2023.	Green
March 24	Development of QI collaborative improvement plans	JM, EW, MCS	All three QI collaborative groups have been established and being delivered within the SUTG plan. Touchpoint in August 2023	Green
March 24	Delivery of the recruitment and agency plan link to (risk 85) including medical workforce Plan	Sarah Willis	Delivery on track. Touchpoint in August 2023	Amber
Dec 2023	Implementation of the Foundations for Great Nursing Care Programme	E. Wallis	On track. Held synthesis event and now consulting on the nursing care principles and delivery outputs .	Green
Aug 23	NHS Long Term Workforce Plan translation for LPT – to build into workforce plan.	Workforce and clinical	Ongoing with touchpoint in August 2023	

Risk No: 85	Date included	August 2022	Date revised	10/07/23
Objective: S	Well Governed			
Risk Title:	High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2023/24			
Risk owner:	Exec: Director of Finance / Director HR		Local: Deputy Director of Finance	
Governance:	EMB/FPC/Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

Controls

Description:

- DRA process ensures all agency shifts appropriately approved against establishment
- Agency spend separately coded on ledger
- Budget reports show agency spend by cost centre & reviewed by budget holders & management accountants
- Pre-approval process for all non-clinical agency staff prior to NHSE approval being sought
- HCL master vend approach ensures agreed rates paid for staff
- Reducing reliance on agency project clearly defined with specific financial target for spend reduction & specific actions
- Agency estimated WTE included on cost centre reports to highlight total level of staffing being used compared to budget
- Establishment control approach put in place to reconcile finance and HR information through ESR and arrive at an accurate staffing picture
- Recruitment plans in place to address administration HCA/HCSW vacancies to zero, and reduce vacancies in other high agency usage workforces
- Budget holder training & 'back to basics' finance engagement programme.
- Refresh of workforce and Agency Reduction Plan following system ops plan and increased CIP

Gaps:

- Off framework and some on framework agencies do not conform to NHSE price caps
- Gaps in establishment in ESR & General ledger reconciliation; staff could be working to different views of the funded establishment
- Operational pressures could lead to higher than planned agency use
- Agency reduction required to deliver 23/24 plan is a material decrease on current usage
- Increased system pressures reference workforce growth and CIPS could impact on agency use

Assurances

	Source:	Evidence:	
Internal:	• Reducing reliance on agency project QI approach & reporting – fortnightly meeting addressing all aspects of agency reduction plan • Operational oversight & management of cost forecasts through Directorate Management Teams • Finance and Performance Committee report includes agency reporting • LLR ICB Finance committee oversight	• Progress reporting to EMB including deep dive in December 22 • Workforce and agency reduction plan received at the new PCC • Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against financial plan, including agency • Mitigation plans for revenue to demonstrate requirements for financial plan delivery, including agency targets • Agency reduction group bi weekly meetings • Deep dive on plan at EMB June	Assurance Rating Amber
External:	• NHSE monitoring of system delivery against Agency ceiling • 360 Assurance audit - agency staffing	Advisory review – no assurance rating provided	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Aug 23	stopping off framework agency use for HCA July	Sarah Willis	2 weekly agency reduction meeting	Amber
Nov 23	Stopping off framework for nursing by Oct	Sarah Willis		Amber
Mar 24	Delivery of the workforce and agency reduction plan.	Sarah Willis	Monthly touchpoint review.	

Risk No: 86	Date included	14/09/22	Date revised	10/07/23
Objective: S	High Standards			
Risk Title:	A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in community mental health services in a timely way, impacting on the safety of care and the mental wellbeing for our patients.			
Risk owner:	Exec Lead: Medical Director		Local: Clinical Director – Planned Care	
Governance:	EMB/QSC/ Board – Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- CMHT task and finish group
- A Planned Treatment and Recovery Team rapid response task and finish group
- Skill mix and career pathway task and finish group
- Workforce solutions in recruitment is supported by Trust policies and processes
- Crisis Team joint referral SOP
- Revised Duty System across all CMHTs
- CMHT workforce and risk assessment action plan
- Mental Health multi professional workforce plan
- pathway for overseas recruitment of consultant psychiatrists
- SUTG MH Transformation Programme
- Revised level 2 Waiting Times Delivery Group chaired by interim Medical Director
- Specific medical workforce plan developed with 9 workstreams to support recruitment, retention, health and well being and career development

Gaps:

- Consultant Psychiatrist vacancies across the AMH planned care teams, the use of locums and the increasing difficulty in recruiting both substantive and locum staff
- Impact of transformation work to move the CMHTs to Planned Treatment and Recovery Teams
- Increased waiting times with repeated cancellations of clinics
- Temporary staff do not always have Approved Clinician status and managing patients on CTOs
- Workforce availability of staff with other skills/ knowledge – NMP's, ACP'S, AC's, Physician Associates, Pharmacists.

Assurances

Internal:

Source:

- Operational risk 5087 Planned Treatment and Recovery Teams Staffing Risk
- Review of measures including complaints, incidents and learning from deaths reported monthly through Quality and Safety DMT.
- Cancelled clinics and waiting time data reported monthly through performance and finance DMT.
- Quality summits – March 22 and September 22
- Caseload reviews progressing – not yet concluded
- CMHT workforce and risk assessment action plan
- Monthly meeting with senior medical leadership team and CEO

Evidence:

- SEB paper Addressing the Consultant Psychiatrist vacancies in DMH – current issues, plans and next steps 1 July 2022
- CMHT Risk Paper to DMT in August 2022.
- Quality Summit briefing to SEB May 2022
- Workstreams that support medical workforce plan reported to SWG

Assurance Rating Amber

External:

Source:

Evidence:

Assurance Rating Amber

Gaps:

Actions

Date:	Actions:	Action Owner	Progress:	Status
Ongoing	Physician Associate recruitment plan	Saquib Muhammad	• Awaiting agreement with RSP and GMC re governance. Touchpoint review in August 23	Amber
Mar 24	Medical workforce plan developing with 9 key workstreams – set within workforce and agency reduction plan	SMuh/ Sarah Willis	• Ongoing progression – monthly touchpoint review	Amber

Risk No: 87	Date included	18 November 2022	Date revised	12/07/2023
Objective: E	Environments			
Risk Title:	Following the establishment of a new FM service, there is a risk of unknown issues based on historical maintenance resulting in the Trust not meeting its quality standards or requirements.			
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities	
Governance:	Estates Committee, FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Tolerance Level Significant 16-20 (Appetite Quality-Seek)			

Controls				
Description:	• Relentless focus on driving up standards, with governance through EMEC • Increased property manager capacity to work with Operational teams on estates management • Compliance manager in post to oversee the data provided by contractors and escalate high risk areas requiring maintenance • Performance metrics with full data availability in development from 1 November 2022			
Gaps:	• Inherited and unquantified unknown issues			

Assurances			
Internal:	Source: Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • In house data (from 1 November 2022) • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Amber
External:	Source: • CQC inspection 2021 • Estates 5 Year Plan (Archus)	Evidence: • CQC report	Assurance Rating Amber
Gaps:	• Missing historical data from previous FM provider		

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Ongoing	Review of financial implications of backlog maintenance and reactive repairs	CFO	Initial review to EMEC before reporting to FPC Ongoing – no finish date. Next touchpoint August 2023	Amber
Ongoing	Compliance and safety testing	CFO	Good progress, compliance increasing	

Risk No: 88	Date included	NOVEMBER 2022	Date revised	10/07/23
Objective: S	High Standards			
Risk Title:	Risk of closed cultures within services that may lead to poor patient, staff and family experience and organisational and reputational risk.			
Risk owner:	Exec Lead: Director of Nursing, AHPs and Quality	Local: Group Director of Patient Safety		
Governance:	QF/QSC/ Board			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- Governance processes and systems (Board to Ward)
- Recruitment and HR processes
- NHS staff survey
- Complaints & PALS processes
- Patient safety investigations, human factors and learning lessons processes
- Freedom to speak up processes and culture
- Cultural change workstream
- Ongoing work to reduce restrictive practices such as seclusion and long-term segregation
- Audits, practice and application of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. This includes application, where required, of Gillick competency and Fraser Guidelines.
- Practice and application of safeguarding processes
- Advocacy support to service users and families
- Community Education Treatment Reviews in Learning Disability Services
- External scrutiny and visits from commissioners, regulators and local authority safeguarding
- Service led self-assessment and quality assurance processes and accreditation programmes
- Service visits by Executive team, Non-Executive Directors, and Governors
- Quality summits and associated improvement programmes within directorates
- Focussed quality & safety reviews (example of Langley ward in March 2023)

Gaps:

- Recognition of closed cultures is not built into staff induction and training, including for bank & agency staff.
- Output of recommendations from Quality & Safety review

Assurances

	Source:	Evidence:	
Internal:	• Trust governance (committees, sub-committees, directorate level) • Patient safety, patient experience & safeguarding groups • Self-assessment & accreditation processes	• Minutes from governance meetings and committees	Assurance Rating Amber
External:	• CQC/MHA visits • Commissioner/LA safeguarding visits	• CQC reports • Commissioner feedback/Safeguarding reviews	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
	• Delivery of recommendations from Quality & Safety review reported to QF/Q&S every 6 months, Update to FFHS monthly	James Mullins	• Action to report to QF and Q&S every 6 months with monthly updates to FFHS	Amber

Risk No: 89	Date included	28/02/23	Date revised	12/07/23
Objective: S	Environment			
Risk Title:	Following the transfer of soft FM service, there are potential gaps in the sustainability of compliance with national cleaning standards and waste regulation which may impact on healthcare acquired infections and patient outcomes.			
Risk owner:	Exec Lead: Chief Finance Officer		Local: Associate Director of Estates and Facilities	
Governance:	IPCC / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- National standards of healthcare cleanliness
- Contract management with NHSPS for provision of soft facilities management (including cleaning standards)
- Use of the Hygiene standards
- LPT estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination)
- Infection control team / IPC 6 monthly report to Trust Board
- SOPs in place to describe key responsibilities
- Audit programme – national standards cleaning audit, IPC audit including cleaning, environmental audits by FM team, pre-acceptance waste audit, internal waste audits
- On outbreak wards staff aligned to task for whole shift
- Rapid response team
- IPC operational meeting
- Environmental checklist in Matron quality and safety checks
- Quality accreditations / 15 steps / boardwalks
- PLACE - patient led assessment of the care environment
- IPC and Estates environment audit programme
- Paper based audits still available – electronic auditing data being reviewed re suitability and report format.
- All facilities (cleaning) management functions recruited to – pending on boarding HR process

Gaps:

- Recruitment. On transfer of services into LPT approximately 20% vacancy rate unfilled by any other sources.
- Clearly defined roles and responsibilities for clinical staff re cleaning
- Appropriately trained staff and records to evidence

Assurances

Internal:

Source:

- Estates Committee (Soft FM report to EMEC (FPC) and IPC (QAC)
- IPC Bi-Annual report to Trust Board
- PLACE reporting – EMEC
- Waste management meetings
- DMTs
- Internal audit programme
- IPC Assurance Group – on target for full implementation of cleaning standards
- Regular performance reports – no full set of cleaning scores available yet.
- PLACE report

- IPC BAF
- Cleaning report
- Waste report
- IA reporting
- IPC walk arounds
- Incident reporting
- Implementation of national standards of healthcare cleanliness including training of both facilities and clinical staff

Assurance Rating Amber

External:

Source:

- CQC inspections including MHA visits
- PLACE – patient and carer led assessments

Evidence:

Good PLACE scores – awaiting benchmark data

CQC feedback has not escalated cleaning as an issue

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Sept 23	Substantive recruitment	Helen Walton/ HR	Currently utilising agency or framework agreements	Amber
Oct 23	Develop and implement training records via uLearn	AoD	FM staff ESR records not pulled through to Ulearn which is impacting on training and appraisals.	Amber

Risk No: 90	Date included	April 2023	Date revised	17/07/23
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2023/24 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).			
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance	
Governance:	EMB / FPC / Board monthly			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)

Controls

Description:

- National planning guidance followed in preparation of the plan
- LPT Financial & Operational Plan triangulated with workforce plan
- Standing Financial Instructions support control environment, Treasury management policy , cash flow forecasting ensure robust cash management
- Capital Financing strategy & plan in place
- LPT draft medium term financial strategy in place & presented to Trust Board April 2022
- UEC collaborative tasked with identifying £17m savings to close planning gap

Gaps:

- Breakeven plan submitted in May - £37m of quantifiable risk highlighted in plan – 8% of expenditure
- Financial pressures in DMH inpatient areas need to be robustly managed
- Operating costs of the Beacon Unit significantly exceed the cost per case income secured.
- Trust wide safer staffing, recruitment & agency reduction assumptions need to be delivered
- Significant efficiency savings - £16m 4% required for break even plan- not fully identified currently
- LLR ICB medium term capital strategy not yet in place
- LLR ICB medium term revenue strategy not yet in place
- LLR ICB Risk/gain share unlikely to be agreed for 23/24 –specific organisational ownership of solutions to UEC risk & financial consequences outstanding
- LLR ICB May plan position was £10m deficit - ICB-break even, UHL-deficit related to urgent & emergency care unfunded costs (£10m)
- In year delivery of system wide plan at risk as at month 3

ICB highest scored operational finance risks:

- Urgent Care Pressure (score 20)
- 23/24 Financial plan delivery (score 16)
- Workforce, recruitment & selection (score 16)
- Delivery of financial strategy (score 16)
- Transformation & efficiency schemes (score 16)

Assurances

Internal:

Source:

- Audit Committee
- Operational oversight & management of cost forecasts through Directorate Management Teams
- Capital Management Committee's oversight of capital delivery and agreed governance processes;
- Finance and Performance Committee report includes I & E, cash & capital reporting
- Delivery against recovery plan actions will be reported monthly via finance report
- LLR ICB Finance committee oversight

Evidence:

- Reports & updates from Internal & external auditors
- Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating
- Ongoing oversight and management of all aspects of financial position against plans
- Monthly reports to EMB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against plan
- Recovery plan weekly meetings & ongoing reporting to SEB, FPC & Trust Board

Assurance Rating Green

External:

Source:

- KPMG audit of 2022/23 annual accounts and value for money conclusion
- 2022/23 Internal audit - Financial systems - focusing on budget setting, reporting and monitoring
- HFMA checklist audit Q3 22/23
- NHSE national & regional leads undertook deep dive into LPT financial plan & agreed it was robust and included real & clearly identified risk.

Evidence:

- 2022/23 annual accounts unqualified opinion
- Significant assurance
- 360 Assurance review complete, report issued & presented to Dec Audit Committee

Assurance Rating Green

Gaps: Following the 2022/23 deficit position, the Trust will have a 2 year period to return to surplus to ensure that the statutory duty to break even 'taking one year with another' over a 3 year rolling period an still be achieved.

Actions

Date:	Actions:	Owner:	Progress:	Status
Aug 23	Close outstanding planning gap – c £2.5m	SM	Recovery plan work ongoing	Amber
Q1 23	Deep dive with NHSE regional team	SM	Completed	Green
Q1 23	Contribute to LLR ICB capital & financial strategy development	SM	In progress	Green
Q1 23	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	In progress	Green
Dec 23	Develop medium term recovery plan, using value in healthcare approach	SM	In progress	Green
Mar 24	Continued monitoring and mgt of the Trust's delivery of 2023/24 financial plan, incl recovery actions	SM	Ongoing	Green

Risk No: 91	Date included	April 2023	Date revised	10.07.23
Objective: A	Access to Neurodevelopmental Assessment and follow-up for children and adults			
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing diagnostic services for ADHD and ASD and timely follow-up, mean that patients may not be able to access the right care at the right time and may lead to poor outcomes and harm.			
Risk owner:	Exec: Medical Director		Local: Director of DMH and FYPCLDA	
Governance:	EMB / FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Tolerance Level Significant 16-20 (Appetite Quality-Seek)			

Controls

Description:

- Access Policy
- Waiting list management approaches and Standardised Operational Processes applied to waiting lists including application of acceptance criteria, patient tracking lists and demand capacity modelling
- Service pathway re-design including triage, pre-assessment screening, digital contacts and skill-mix
- System planning (design groups) established to identify system risks and investment required
- Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information
- Managing patient expectation through sharing approximate waiting times
- Access Delivery Group
- Non-recurrent funding for AAADs and Community Paediatrics
- Local Authority funding for ADHD over 3 years
- System QIA for the unsuccessful business case
- Group AHDH workshop with NHFT to share learning – June 2023

Gaps:

- Capacity and resources
- No investment in 23/24 for business cases for CYP ND, AAADs – confirmed by ICB on 6 June 2023

Assurances

Internal:

Source:	Evidence:	
• Executive Management Board – Performance reviews • Directorate level deep dives. • Waiting time performance reported to Finance and Performance Committee • Checks of safety of patients waiting in CAMHS • Directorate level risks relating to AADS, CYP ND and ADHD waiting times • Transformation and QI Group	• Performance dashboards and reporting to DMTs, EMB and Trust Board • Business case setting out the case of need for CYP • Business case setting out case of need for adults with Autism • Re-designed pathways • Directorate Risk, actions and mitigations	Assurance Rating Amber

External:

Source:	Evidence:	
• CYP design Group • LLR LDA Collaborative • ND Board • LLR Mental Health Collaborative	• Meeting minutes and action logs • QIAs reviewed through system quality group • System risk register • System ND transformation group to be established to identified and support areas of risk.	Assurance Rating Amber

Gaps:

Actions

Date:	Actions:	Owner:	Progressing – next touchpoint August 2023	Status
Aug 23	Benchmark autism services against national framework for Autism diagnosis	Directors		Amber
Aug 23	Re-establish Mental Health/ADHD transition group	FYPCLDA/DMH		
Aug 23	Agree revised performance trajectories for 23/24	"		
Sept 23	Recruit to non-recurrently funded vacancies	"		
Oct 2023	Report on Q1/2 progress with CYP ND transformation project	"		

Risk No: 92	Date included	May 2023	Date revised	11/07/2023
Objective: S	High Standards			
Risk Title:	Increasing demand and insufficient staffing in the Looked After Children nursing team is resulting in long wait times for LAC (5-18), which may cause harm to our patients and may prevent us from meeting our statutory responsibilities			
Risk owner:	Exec: Helen Thompson		Local: Janet Harrison	
Governance:	SEB / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	2	8

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls

Description:

- Access policy
- Standard operating procedures
- Prioritisation model
- Service specification
- Use of bank staffing
- Approved Business Case (April2023) for additional funding for team members
- Social worker as corporate parents (LA) with 6 monthly review (inc. face to face)
- Approved skill-mix model
- New models of working agreed including virtual RHAs with inclusion criteria
- New starters onboarded (2.6 wte)

Gaps:

- Timely health assessment for LAC (5-18yrs)
- Current substantive WTE availability

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	Safeguarding Assurance Group and Safeguarding Committee FYPC/LD DMT	Regular reporting Minutes and improvement plan Feature on LAC at Trust Board in August 2023	Amber
External:	CYP Collaborative oversight (monthly) Designated nurse for LAC at ICB – oversight	CYP Collaborative – monthly update Quarterly report to designated nurse – RAG rating RED for Review Health Assessment Approved business case	Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Status
July 2023	Review of standard operating policy based on new ways of working	John Scaysbrook	Amber
July 2023	Developing trajectories	JS	
Oct 2023	Continue to recruit and onboard to agreed clinical model in BC	JS	
Oct 2023	Mobilise enhanced LAC 5-18 service	JS	
Nov 2023	LLR LAC Summit	DN, NN LAC	

Risk Scoring and Appetite

Leicestershire Partnership
NHS Trust

Risk Scoring Matrix

The following matrix is used to grade risk
The scores obtained from individual consequence and likelihood risk scoring are assigned grades as follows;
1 Very Low (green)
2 Low (yellow)
3 Moderate (Amber)
4 High (red)
5 Significant (red)

The following matrix is used to grade **combined** risk scores. Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

Risk Appetite and Tolerance Level

Risk type	Appetite level	Appetite Descriptor	Tolerance	Tolerance Descriptor
Financial	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Regulatory	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Quality	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Reputational	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
People	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).

Based on the risk appetite matrix produced by the Good Governance Institute